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HMO/PHYSICIAN PREFERRED NETWORK

Certificate of Coverage

Non-Grandfathered



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OVERVIEW

The Total Health Care USA Physician Preferred Network Plan is a HMO Plan that allows you the flexibility to select from two networks to receive care. In this Plan you must choose a primary care physician from one of the two networks. The two networks have varying out of pocket cost depending on the benefit. Amounts that a member may be responsible for include the following:

Deductible: A set amount that you pay each year before Total Health Care USA makes a payment.

- Physician Preferred Network (PPN) - \$250 individual / \$650 Family
- Total Health Care (THC) Network - \$500 individual / \$1,300 Family
- Deductible payments do not carry over into the other network.
- The Deductible applies to the Out-of-Pocket maximum.

Co-Payment: The amount a member must pay per visit or service for certain covered benefits.

A Co-Payment does not apply to the Deductible or Out-of-Pocket maximum.

	PHYSICIAN PREFERRED NETWORK	THC NETWORK
Office Visit	\$0	\$10

Out-of-Pocket Maximum: Maximum amount Deductible that a member and/or family will have to pay during a Calendar Year. If the Out-of-Pocket maximum is met, Total Health Care will pay all eligible expenses for covered services for the remainder of the Calendar Year.

PHYSICIAN PREFERRED NETWORK

- Lower Deductible
- Lowest Co-Payments
- Lower Out-of-Pocket maximum
- No Coinsurance

TOTAL HEALTH CARE NETWORK

- Higher Deductible
- Higher Co-Payments
- Higher Out-of-Pocket maximum
- No Coinsurance

The Physician Preferred Network HMO plan gives you the freedom to select your provider. The example below illustrates the Out-of-Pocket cost for a Total Health Care USA member in the Physician Preferred Network Plan. This Certificate of Coverage details this plan.

	PPN NETWORK	THC USA NETWORK
Bill Amount	\$2,000	\$2,000
Allowable/contracted rate	\$1,160	\$1,160
Deductible Paid by Member	\$250	\$500
Amount THC pays (allowable less Deductible & Coinsurance)	\$910	\$660
TOTAL AMOUNT YOU PAY	\$250	\$500

ARTICLE I. TOTAL HEALTH CARE USA, INC.

Total Health Care USA, Inc. is a nonprofit corporation organized and licensed under the laws of the State of Michigan, with its address at 3011 W. Grand Blvd., Suite 1600, Detroit MI 48202-3000.

ARTICLE II. DEFINITIONS

- 2.01 When used in this Certificate of Coverage, Riders, the Group Operating Agreement, the Enrollment Application signed by the Subscriber and the identification card issued to Members, the definitions in Sections 2.02 to 2.37 apply.
- 2.02 "Affiliated Facility" means any legally qualified and state-licensed intermediate care or skilled nursing facility or Hospice, which has a contract with the Plan to provide services for Members.
- 2.03 "Affiliated Hospital" means any hospital that has a contract with the Plan to provide hospital services to Members.
- 2.04 "Affiliated Physician" means an individual licensed to practice medicine or osteopathy and who has a contract with the Plan or an IPA to provide services to Members.
- 2.05 "Affiliated Provider" means a health professional, a hospital, licensed pharmacy or any other institution, organization or person who has a contract with the Plan or an IPA to render one (1) or more health maintenance services to Members.
- 2.06 "Affiliated Psychiatrist" means an individual licensed to practice psychiatry and who has a contract with the Plan to provide services to Members.
- 2.07 "Authorized Benefits and Services" are those health care benefits and services available to Members under this Certificate when provided by health care providers authorized to provide such care under this Certificate.
- 2.08 "Calendar Year" means twelve (12) month period of benefit coverage that begins on January 1. Deductible amounts are reset at the beginning of each Calendar Year.

- 2.09 "Certificate" means this Certificate of Coverage Agreement and applicable Riders.
- 2.10 "Coinsurance" means the percentage of the portion of contracted payment that each Member must pay per visit to a treating Provider for Authorized Benefits.
- 2.11 "Contract Year" means the twelve (12) month period from the date that coverage was initially effective under this Certificate and each twelve (12) month period thereafter, unless otherwise stated and agreed upon.
- 2.12 "Co-Payment" means the dollar amount each Member must pay per visit to a treating provider in connection with Authorized Benefits and Services.
- 2.13 "Deductible" means the amount of money each member is responsible to pay for covered Services during a Calendar Year before the Total Health Care USA payment begins. Each Calendar Year begins a new Deductible period.
- 2.14 "Dependent" means any of the following, unless otherwise excluded by the Group Operating Agreement:
- (1) The Spouse of a Subscriber;
 - (2) Child of the Spouse or Subscriber by birth, legal adoption or legal guardianship who has not attained the age of twenty-six (26); and
 - (3) Who is not offered any health coverage by their employer.
- A child need not be claimed as a Dependent on the federal income tax return of the Subscriber to qualify as a Dependent.
- 2.15 "Enrollment Application" means the form approved by the Plan by which an individual seeks to enroll one or more Members in the Plan.
- 2.16 "Grace Period" means the thirty (30) day period allowed for payment of the Premium immediately following the due date for the Premium.
- 2.17 "Group" means an employer group or organization that has executed the Group Operating Agreement on behalf of its employees or members.
- 2.18 "Group Operating Agreement" means the agreement entered into between the Plan and the Group through its authorized representative, which outlines the criteria of eligibility of persons to be Members of the Group, and which together with any agreement regarding new and rehired group employees, the Certificate, the Enrollment Application and the Member identification card constitutes the contract between the Plan, the Group and the Member.
- 2.19 "Health Center" means a health care facility that is operated by an Individual Practice Association.

- 2.20 "Hospice" means a licensed health care program that has a contract with the Plan to provide a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.
- 2.21 "Hospital" means a state-licensed acute care facility that provides inpatient, outpatient, and emergency medical, surgical, or psychiatric diagnosis, treatment and care of injured or acutely sick persons, by or under the supervision of a staff of physicians and that continuously provides twenty-four (24) hour-a-day nursing service by registered nurses, and which is not, other than incidentally, a place for the treatment of pulmonary tuberculosis, a place for the treatment of drug abuse, a place for the treatment of alcoholism, nor a nursing home.
- 2.22 "Individual Practice Association" or IPA means a partnership, corporation, association, or other entity that has a contract with a Plan to provide and arrange for services to Members, has as its primary objective the delivery, or arrangement for the delivery, of health care services, and employs or has entered into written service agreements with health professionals, a majority of whom are physicians.
- 2.23 "Medical Emergency or Accidental Injury":
- (1) "Medical Emergency" means a medical condition manifested by severe symptoms occurring suddenly and unexpectedly which could reasonably be expected to result in serious physical impairment or loss of life if not treated immediately.
 - (2) "Accidental Injury" means a traumatic bodily injury that, if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize a Member's health or result in loss of life.
 - (3) Heart attacks, hemorrhaging, poisoning, loss of consciousness or respiration, trauma, and convulsions are some examples of Medical Emergencies or Accidental Injuries.
- 2.24 "Member" means a Subscriber or Dependent eligible to receive services under this Certificate and the Group Operating Agreement, and who has enrolled in the Plan.
- 2.25 "Open Enrollment Period" means that limited period of time during which eligible persons are given the opportunity to enroll in the Plan.
- 2.26 "Plan" means Total Health Care USA, Inc.
- 2.27 "Preferred Network" means a group of physicians designated as Preferred Providers and indicated in a Physician Directory as Preferred Network Providers.
- 2.28 "Premium" means the amount of money prepaid monthly by a Group, including Subscriber contributions, if any, on behalf of the Members.
- 2.29 "Breast Rehabilitative Services" means a procedure intended to improve the results of, or ameliorate the debilitating consequences of treatment of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to, reconstructive plastic surgery, physical therapy, and psychological and social support services.

- 2.30 "Referral Facility" means any legally qualified and state-licensed intermediate care facility, skilled nursing facility, Hospice or Hospital that provides services to Members under the orders of an Affiliated Physician or Referral Physician when admission is authorized by the Affiliated Physician and the Plan's Medical Director or his/her designee.
- 2.31 "Referral Physician" means a physician other than an Affiliated Physician who is licensed to practice medicine or osteopathy and who delivers medical or osteopathic care to a Member on the referring order of an Affiliated Physician.
- 2.32 "Remitting Agent" means the Group or the person designated by the Group who is responsible for the payment of the monthly premiums.
- 2.33 "Semi-Private Room" means hospital accommodations where there are two (2) or more bed to a room.
- 2.34 "Service Area" means the geographic area where the Plan is available and readily accessible to Members and where the Plan has been approved by the State of Michigan to market its services.
- 2.35 "Spouse" means the legally married husband or wife of a Subscriber.
- 2.36 "Subscriber" means an individual who enters into an HMO contract, or on whose behalf an HMO contract is entered into, with an HMO that has received a certificate of authority from the State of Michigan and to whom an HMO contract is issued:
- (1) Who meets all eligibility criteria established by the Group Operating Agreement and this Certificate; and
 - (2) Who has completed an Enrollment Application which has been received by the Plan; and
 - (3) Who resides within the Service Area at the time of application; and For whom Premiums have been received.
- 2.37 "Preventative Benefits" means covered services that are intended to prevent disease while it is more easily treatable as defined by the US Preventative Services taskforce A and B recommendations.

ARTICLE III. ENROLLMENT; EFFECTIVE DATE OF COVERAGE; PREMIUMS

- 3.01 Enrollment
- (1) Persons meeting the Group and Plan's eligibility requirements during an Open Enrollment Period may enroll in the Plan only during that Open Enrollment Period. In order to enroll, an Enrollment Application must be completed and received by the Group during the Open Enrollment Period.

A person who is an eligible person at the time of an Open Enrollment Period and not already a Subscriber who fails to enroll during such Open Enrollment Period shall not be entitled to enroll at a later date except during a subsequent Open Enrollment Period.

- (2) Persons who join the Group between Open Enrollment Periods, or otherwise become eligible to enroll in the Plan for the first time, may do so by completing an Enrollment Application within thirty (30) days of attaining eligibility pursuant to the Group Operating Agreement. In the event that such a newly eligible person fails to complete and submit an Enrollment Application within this thirty (30) day time period, the person shall be entitled to enroll in the Plan only during a subsequent Open Enrollment Period.
- (3) All newborn coverage starts at birth. To be covered a member must enroll the newborn and pay any premium within thirty-one (31) days of birth.

3.02 Effective Date of Coverage

- (1) Except as limited in subsection (3) below, the effective date of coverage for Members who enroll during an Open Enrollment Period, will be the date agreed upon in the Group Operating Agreement, provided that the signed Enrollment Application and appropriate Premium have been received by the Plan.
- (2) Except as limited in subsection (3) below, and unless otherwise provided in the Group Operating Agreement, the effective date of coverage for newly eligible Members who enroll between Open Enrollment Periods, shall be the first day of the month following the month of the Plan's receipt of the signed Enrollment Application and Premium.

3.03 Premiums

Premiums shall be paid to the Plan at the rate established by the Plan for coverage under this Certificate as set forth in a written notice by the Plan to the Remitting Agent. All Premiums are to be remitted on a monthly basis on or before the first day of each month unless otherwise agreed upon in writing by the Plan and Remitting Agent.

If the Premium is paid by the Group to the Plan during the thirty-one (31) day Grace Period, there will be no lapse in coverage.

If the Premium is not received within the Grace Period, the Plan may terminate the Group Operating Agreement and this Certificate in accordance with Article X. In the event of termination, the Plan reserves the right to recover from the Group the cost of services rendered during the period following the due date; and to reject claims submitted by providers for services rendered during the period following the due date. Termination shall be effective retroactively to the due date of said Premium.

ARTICLE IV. GENERAL CONDITIONS

- 4.01 In completing the Enrollment Application, each Subscriber selects a Primary Care Physician from either the Preferred Network or the Total Health Care Network. The selection of a Primary Care Physician will determine the level of the Deductible. Each Member agrees and understands that all Authorized Benefits and Services must be provided by or authorized and arranged through this designated Primary Care Physician, except in the event of a Medical Emergency or Accidental Injury. If a Member cannot recall the Primary Care Physician selected or needs further information, the Member should contact the Plan's Member Services Department at (313) 871-2000.

- 4.02 Inability, failure, neglect, and/or refusal of an IPA to provide Authorized Benefits and Services, shall give the Plan the right to transfer Members covered from one Primary Care Physician to another Primary Care Physician during such inability, failure, neglect, and/or refusal. The Plan's right to transfer Members will be exercised in the best interests of the Members' health care needs and within the legal limitations dealing with termination of medical care to patients. In the event of such a transfer, the Plan does not guarantee that transferred Members will return to the former Primary Care Physician in the future.
- 4.03 Nothing contained within this Certificate shall interfere with the professional relationship between the Member and the physician providing care. Each Member shall have the right to choose, to the extent feasible and appropriate, the Affiliated Physician and other health care professionals responsible for his/her primary care, subject to the provisions in Section 11.10. Each IPA maintains medical records at the designated Primary Care Physician for each Member receiving services. The medical records are available for inspection and review during regular business hours upon request by the Member.
- 4.04 No officer, agent, or representative of the Plan except the Executive Director is authorized to vary the terms or conditions of this Certificate in any way or to make any promises or agreements supplemental to this Certificate. Any supplemental agreements or variances to the terms or conditions of this Certificate must be in writing signed by the Executive Director of the Plan.
- 4.05 The Authorized Benefits and Services provided under this Certificate are solely for the individual benefit of the Members and cannot be transferred or assigned. If any Member aids, attempts to aid, or knowingly permits any other person not a Member of the Plan to obtain benefits or services from or through the Plan, that Member's coverage under this Certificate shall be terminated immediately, and the Member shall be responsible for payment for any services rendered to such other person. The theft or wrongful use, delivery, or circulation of a Member identification card may constitute a felony under Michigan law.
- 4.06 If a Member's identification card is lost or stolen, the Member must contact the Plan's Member Services Department at (313) 871-2000 by the close of the business day following discovery of theft or loss. Failure to notify of the loss or theft of a Member identification card within that time period shall result in the termination of coverage under this Certificate.
- 4.07 When a Member enrolls in the Plan, she/he shall be deemed to have agreed to use Affiliated or Referral Physicians and Affiliated or Referral Facilities and other Providers for all services and supplies, except in case of a Medical Emergency or Accidental Injury.
- 4.08 This Certificate supersedes all previous contracts or certificates between the Plan, the Group, and the Members.
- 4.09 Any notice required to be given by the Plan, the Group or a Member, shall be deemed to have been duly given if in writing and personally delivered, or deposited in the United States mail

with postage prepaid, addressed, as applicable, to the Remitting Agent, to the Member at the last address on record at the Plan's principal office, or to the Plan at 3011 W. Grand Blvd., Suite 1600, Detroit, Michigan 48202.

4.10 The Plan shall not be liable for any delay or failure of an Affiliated Provider, Referral Physician, or Referral Facility to provide services due to lack of available facilities or personnel, if the lack is a result of circumstances beyond the Plan's control. In the event of circumstances beyond the Plan's control, the Plan shall attempt to arrange Authorized Benefits and Services, in so far as practical, according to its best judgment and within the limitations of facilities and personnel then available. Circumstances beyond the Plan's control include, but are not limited to, complete or partial disruption of facilities, war, riot, civil insurrection, epidemic, labor disputes, unavailability of supplies, disability of a significant part of an Affiliated Provider's personnel, or similar causes.

4.11 Complaint, Grievance, and Appeal Process:

The Plan has a procedure to assist any Member who has a complaint or appeal regarding any aspect of the Plan's services. The Plan will provide each Member with a written explanation of the procedure upon enrollment in the Plan and/or at any time upon request. A Member can call the Plan to voice a complaint, or write to the Plan to file a written complaint/grievance. The complaint/grievance should be directed to:

Total Health Care USA
Attention: Grievance Coordinator
3011 W. Grand Blvd., Suite 1600, Detroit, MI 48202
Phone: (313) 871-7889
Fax: (313) 871-0196
e-mail: results@thc-online.com

When filing a complaint, another person can act as the Member's authorized representative. To use an authorized representative, written notification must be submitted to Total Health Care authorizing the person to act on behalf of the Member.

Grievance

A grievance is the process used to handle a complaint. A grievance may be due to a denial of payment or an adverse determination. An adverse determination means health care services have been reviewed and denied, reduced, or terminated. An untimely response to a request becomes an adverse determination. Members or their authorized representative have one hundred and eighty (180) days from the date of the notification letter to file a grievance.

Covered benefits continue pending resolution of the grievance. Members have the right to authorize someone to act as an authorized representative in the grievance. An authorized representative must have the Member's written permission to represent them. Members have the right to send additional documentation with the grievance.

Members have the right to ask Total Health Care to arrange a meeting with the Appeal Review Committee. Members or an authorized representative may attend the meeting in person or by telephone. A person not involved in the first decision will review the grievance. No one who reports to the person involved in the initial decision can review the grievance. The person who reviews the grievance will be of similar specialty.

Medical grievance will be completed within thirty (30) calendar days after receipt. Administrative or denial of payment grievance will be completed within thirty-five (35) calendar days after it is received. Members will be notified in writing of the final decision. If the decision upholds the denial, an external appeal can be filed. The final letter explains external appeal rights and how to file the appeal.

Expedited Grievance

An expedited review of a grievance will be made when a physician notifies us verbally or in writing that waiting the thirty (30) days would cause the Member to have severe pain or put their life at risk. The physician must be able to support the attestation. The grievance must be received within ten (10) days of the denial.

After filing an expedited internal grievance with Total Health Care, an appeal and request may be filed for an expedited external review with the Office of Financial and Insurance Regulation (OFIR). If a request for an expedited grievance is denied, it is changed to a thirty (30) day grievance.

A decision about an expedited grievance is made no later than seventy-two (72) hours after it is received. A request for an extension of the decision time moves the grievance to a thirty (30) day grievance.

Total Health Care will notify the Member of the decision by phone. The decision will also be mailed to the Member within two (2) business days.

If the decision upholds the denial, the specific reasons for the final denial will be provided. The notification letter will include the benefit provision, guideline, protocol, or other criteria used. Upon request, access to and copies of all papers related to the grievance are provided.

External Appeal Rights

A Member or authorized representative has the right to request an external review from OFIR. The request should be made after receiving Total Health Care's final decision. Notification of the final decision completes the Total Health Care internal appeal process.

A Member or authorized representative must file the OFIR, Health Care-Request for External Review Form to be given an external review. A copy of the Health Care-Request for External Review Form will be included with the final decision letter. Members may also call OFIR at

1-877-999-6442 to have a form mailed. The form should be filed no later than sixty (60) days after receipt of the final decision letter.

When appropriate OFIR will request a recommendation by an independent review organization. The independent review organization is not a part of Total Health Care. The Commissioner of OFIR will issue a final order.

To ask questions about the external review process, contact the Total Health Care Grievance Coordinator at (313) 871-7889 or 1-800-826-2862 x889.

To request an independent review write to:

Health Plan Division
Appeals Section
Office of Financial and Insurance Regulation
P.O. Box 30220
Lansing, Michigan 48909-7720
Or call: (877) 999-6442
Or fax: (517) 241-4168

- 4.12 All Member protected health information (PHI) is maintained in a manner that assures confidentiality consistent with applicable law. PHI includes electronic, written, and spoken information as a Member's name, address, phone number, Social Security Number, demographic information, and any information related to his/her health condition or diagnosis. The Member has the right to inspect and review their medical records. The Plan will not use or disclose PHI concerning Members and/or their medical treatment other than for purposes of treatment, payment, or health care operations except upon written authorization of the Member or as otherwise required by law. Any such disclosure of PHI will be limited to that which is minimally necessary.
- 4.13 The Plan may adopt reasonable policies, procedures, and rules to promote orderly and efficient administration of this Certificate. Questions about such policies should be directed, in writing, to:

Total Health Care USA
3011 W. Grand Boulevard, Suite 1600
Detroit, MI 48202
Attn: Marketing Dept.

- 4.14 The Member identification card is the property of the Plan. Each Member understands and agrees to return the Member identification card upon request of the Plan.
- 4.15 As a Member of the Plan, the Plan will provide you, upon your request, with a description of any of the following. To request this information, please contact the Member Services Department by telephone at (313) 871-2000, or mail your request to the Member Services Department at:

Total Health Care USA
3011 W. Grand Boulevard, Suite 1600
Detroit, MI 48202

Be sure to include your Member ID number on your request.

- A. Information Concerning Affiliated Providers. The Directory includes the names of Plan Affiliated Providers, specialty or type of practice, practice location, and information concerning accessibility/availability. You may request from the Member Services Department, and the Plan will provide you with:
- Clarification with respect to the information contained in the Directory.
 - Information concerning which Affiliated Providers are not accepting new Plan Members.
 - Information concerning the professional credentials of Affiliated Providers that are health professionals, including professionals certified in the specialty of pain medicine, evaluation and management. The type of information available includes, but is not necessarily limited to, professional degrees held, dates of certification by professional boards and other professional bodies, affiliation status with Affiliated Providers that are facilities, such as hospitals.
- B. Financial Relationships with Affiliated Providers. You may request from the Member Services Department, and the Plan will provide, information indicating the nature of financial relationships between the Plan and its Affiliated Providers. The Plan will provide you with a description of its financial relationships with Affiliated Providers including:
- Whether a fee-for-service arrangement exists, under which the Affiliated Provider is paid a specific amount for each Covered Service rendered to a Member.
 - Whether a capitation arrangement exists, under which a fixed amount is paid to the Affiliated Provider for all, or a specified set, of Covered Services that are or may be rendered to the Member, or all persons in the Members' family covered by the Plan.
 - Whether payments to Affiliated Providers are based on standards relating to cost, quality, and/or patient satisfaction.
- C. Licensure Verification. You can verify the license of Affiliated Providers that are health professionals through the Michigan Department of Labor and Economic Growth. You can verify a license electronically at the following websites: <http://www.cis.state.mi.us/verify.htm> and <http://www.cis.state.mi.us/free/default.asp>. You also can verify a license, and request information concerning disciplinary action and open formal complaints filed against a health professional, by calling the Michigan Department of Labor and Economic Growth at (517) 241-9427.
- D. Benefits. This Certificate of Coverage Agreement, together with any Riders, and the Member Handbook provided to Members, contains a description of the benefits available to Plan Members, including rules regarding accessing benefits such as prior authorization

requirements for specialist services, Referral Physicians, Referral Facilities and other services, drug formulary requirements, if any, and exclusions and limitations applicable to the specific categories of benefits provided. If you require clarification with respect to any of this information, please contact the Member Services Department.

- E. Affiliated Provider Termination. In the event of termination, Members in an ongoing course of treatment with an Affiliated Physician or Referral Physician shall be permitted to continue such treatment with Plan authorization as follows:
- 1) For a period of ninety (90) days from the date the Member is notified of the termination;
 - 2) If the Member is in the second or third trimester of pregnancy, treatment shall continue through post-partum care;
 - 3) If it is determined that the Member is terminally ill as defined in Section 5653 of the public health code, treatment will continue for the remainder of the Member's life for care directly related to the treatment of terminal illness.

4.16 Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

4.17 A Deductible carry-over from the prior carrier applies for eligible expenses incurred within ninety (90) days of the Group's effective date with Total Health Care USA. The Member must provide documentation of the expense within 60-days of the initial Total Health Care USA effective date. The Deductible carry-over does not accumulate toward the Out-of-Pocket Maximum.

ARTICLE V. COVERED BENEFITS AND SERVICES

CALENDAR YEAR DEDUCTIBLE:

In Preferred Network: Employee \$250, Family \$650

In Total Health Care Network: Employee \$500, Family \$1,300

5.01 Inpatient Hospital Care

(1) Physician Services:

All Affiliated Physician services, and Referral Physician services when authorized by an Affiliated Physician, which are deemed necessary for the medical, surgical, obstetrical, and related diagnosis and treatment of a Member, are Authorized Benefits and Services.

(2) Hospital Services:

When a Member is admitted to an Affiliated Hospital or any other Hospital upon authorization of an Affiliated Physician and the Plan's Medical Director or his/her designee,

the Member is entitled to the following Authorized Benefits and Services when deemed necessary for the medical, surgical, obstetrical, and related diagnosis and treatment of the Member:

- a. A Semi-Private Room, including general nursing services, meals, and special diets.
- b. Use of intensive care units, operating rooms, delivery rooms, recovery rooms, and other special treatment rooms.
- c. Anesthesia services.
- d. Laboratory examinations, including typing of blood donors and other diagnostic and pathological services.
- e. All necessary medical and surgical supplies.
- f. Use of X-ray and other diagnostic and therapeutic services.
- g. Drugs, biologicals and related preparations as prescribed by the attending physician.
- h. Maternity and nursery care of at least forty-eight (48) hours following childbirth (ninety-six (96) hour minimum stay in the case of a cesarean section).
- i. Radiation and inhalation therapy.
- j. Medical rehabilitative services and physical therapy which an Affiliated Physician determines can be expected to result in significant improvement of the Member's condition.
- k. Other inpatient services medically necessary for admission, diagnosis, and treatment of the Member.

Subject to Deductible, then covered in full.

5.02 Outpatient Services

- a. Outpatient surgical care, including routine surgical procedures that do not require the use of inpatient hospital facilities.
- b. Therapeutic and diagnostic laboratory, pathology, radiology, and special diagnostic services, which are medically necessary for the diagnosis or treatment of a disease, injury, or medical condition.
- c. Medical and surgical supplies.
- d. Pre-hospital admission screening procedures, which have been authorized by a Treating Physician and/or the admitting physician.

Subject to Deductible, then covered in full.

5.03 Professional Services

(1) The following Authorized Benefits and Services are available for preventive, diagnostic, therapeutic, and rehabilitative care when provided by an Affiliated Physician, health care personnel employed by or having written service agreements with an IPA, personnel employed by the Plan, or by a Referral Physician when authorized by an Affiliated Physician:

- a. Office visits at the Member's designated Primary Care Physician.
- b. Specialty Care Physicians.

- c. Formulary drugs administered at the primary care office.
- d. Outpatient surgical procedures performed in physician's office.
- e. Medical and surgical supplies.
- f. Therapeutic and diagnostic laboratory, pathology, radiology, and special diagnostic services which are medically necessary for the diagnosis or treatment of a disease, injury, or medical condition when authorized by an Affiliated Physician.
- g. Short-term medical rehabilitative services and physical therapy for up to forty-five (45) days per Calendar Year, for conditions which an Affiliated Physician expects will result in significant improvement of a Member's condition within a period of two (2) months.
- h. Pre-hospital admission screening procedures which have been authorized by an Affiliated Physician and/or the admitting physician.
- i. Chiropractic care (limited to twenty (20) visits per Calendar Year).
- j. Pre and post natal care and annual well woman exams. (No referral required when seeing an Affiliated Provider).
- k. Vision and hearing screenings for dependents through the age of eighteen (18) to determine the need for vision and/or hearing corrections.

(2) Home Health Care Aides

When prescribed by an Affiliated Physician, home health care visits by nursing personnel will be provided up to one hundred (100) visits per Calendar Year.

Co-Payment:

Within Preferred Network: \$0

Within Total Health Care USA Network: \$10.00

5.04 Clinical Preventive Service Benefits

1. The following Authorized Benefits and Services are available for preventive care.
 - Immunization for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP);
2. For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;
3. With respect to women evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;
4. Evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force:
 - a. Abdominal aortic aneurysm screening: men
 - b. Alcohol misuse counseling
 - c. Aspirin therapy counseling to prevent CVD: men and women
 - d. Blood pressure screening
 - e. BRCA screening: counseling
 - f. Breast cancer preventive medication
 - g. Breast cancer screening

- h. Breastfeeding counseling
- i. Cervical cancer screening
- j. Chlamydial infection screening: women
- k. Cholesterol abnormalities screening: men and women
- l. Colorectal cancer screening
- m. Dental caries chemoprevention: preschool children
- n. Depression screening: adolescents and adults
- o. Diabetes screening
- p. Folic acid supplementation
- q. Gonorrhea prophylactic medication: newborns
- r. Gonorrhea screening: women
- s. Healthy diet counseling
- t. Hearing loss screening: newborns
- u. Hemoglobinopathies screening: newborns
- v. Hepatitis B screening: pregnant women
- w. HIV screening
- x. Hypothyroidism screening: newborns
- y. Iron supplementation in children
- z. Obesity screening, counseling and behavioral interventions: adults
- aa. Obesity screening, counseling and comprehensive behavioral intervention; children
- bb. Osteoporosis screening: women
- cc. PKU screening: newborns
- dd. Rh incompatibility screening: first pregnancy visit
- ee. Rh incompatibility screening: twenty-four (24) to twenty-eight (28) weeks gestation
- ff. STIs counseling
- gg. Tobacco use counseling and interventions: adults
- hh. Syphilis screening: non-pregnant persons
- ii. Syphilis screening: pregnant women
- jj. Visual acuity screening: children under five (5) years

These Benefits are subject to change. If you have any questions, please contact us at (313) 871-2000

Covered in full.

5.05 Breast Cancer Diagnostic Services and Breast Cancer Screening

Coverage is for one (1) mammography screening every year for women forty (40) years and older. Any other medically indicated mammography is covered. Breast cancer diagnostic services means a procedure intended to aid in the diagnosis of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to surgical breast biopsy and pathological examination and interpretation.

Covered in full.

5.06 Breast Cancer Treatment

Breast cancer treatment delivered on an inpatient or outpatient basis including, but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

Subject to Deductible, then covered in full.

5.07 Other Breast Services and Treatment following a Mastectomy

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction on the breast to produce a symmetrical appearance;
- Prosthesis (breast implant); and
- Treatment for physical complications of the mastectomy, including lymphedema.

Subject to Deductible, then covered in full.

5.08 Diabetic Services

The Plan shall provide coverage for the following equipment, supplies, and educational training for the treatment of diabetes, if determined to be medically necessary, meets established criteria, and is prescribed by a licensed allopathic or osteopathic physician:

- Blood glucose monitors and blood glucose monitors for the legally blind.
- Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.
- Syringes.
- Insulin pumps and medical supplies required for the use of the insulin pump.
- Diabetes self-management training to ensure that Members with diabetes are trained as to the proper self-management and treatment of the diabetic condition.

Covered in full.

- Insulin and other medications for the treatment of diabetes and associated conditions, if the Member subscribes to the Prescription Rider.

Co-Payment is subject to the Prescription Drug Rider.

5.09 Antineoplastic Drug Coverage (Chemotherapy)

The Plan covers drugs used in antineoplastic therapy and the reasonable cost of its administration. Coverage for neoplastic drugs is provided, regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the Federal Food and Drug Administration, if all of the following conditions are met:

- The drug is ordered by a physician for the treatment of a specific type of neoplasm.
- The drug is approved by the Federal Food and Drug Administration for use in antineoplastic therapy.
- The drug is used as part of an antineoplastic drug regimen.

- Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.
- The physician has obtained informed consent from the patient for the treatment regimen that includes Federal Food and Drug Administration-approved drugs for off-label indications.

Deductible may apply, consult your Riders.

5.10 Intermediate and Outpatient Care for Substance Abuse

Intermediate and outpatient care for substance abuse will be provided as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs when prescribed by the Psychiatrist.

“Intermediate care” means the use, in a full twenty-four (24) hour residential therapy setting, or in a partial, less than twenty-four (24) hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

- (i) Chemotherapy.
- (ii) Counseling.
- (iii) Detoxification services.
- (iv) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

Subject to Deductible, then covered in full.

“Outpatient care” means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

- (i) Chemotherapy.
- (ii) Counseling.
- (iii) Detoxification services.
- (iv) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

Covered in full.

5.11 Behavioral Health

- 1) Visits for behavioral health consultation, diagnosis and treatment including crisis intervention, group therapy and testing by a psychiatrist, psychiatric social worker, or a counseling or clinical psychologist.

Covered in full.

- 2) Inpatient Psychiatric Care shall be covered when authorized by the Plan’s Medical Director and/or his designee.

Inpatient Psychiatric Care subject to Deductible, then covered in full.

5.12 Emergency Care

- (1) Emergency medical care coverage is provided for Medical Emergencies and Accidental Injuries if the Member follows the procedures set forth in subsection (2). Emergency medical care is available twenty-four (24) hours-a-day.
- (2) Outpatient follow-up services necessary for the continued treatment of a Medical Emergency or Accidental Injury are covered in the Member's designated Primary Care Physician office only, unless specifically authorized in writing by the Plan's Medical Director or designee.

Co-Payment may apply consult your Riders.

5.13 Ambulance Service

- (1) Ambulance service will be provided when deemed medically necessary, as determined by the Plan's Medical Director or designee according to the following criteria:
 - a. If the Member is admitted as an inpatient to the Hospital immediately following emergency room treatment; or
 - b. When necessary for management of shock, trauma, unconsciousness, heart attack, or other condition requiring active medical management prior to availability of hospital care; or
 - c. When an ambulance is ordered by an employer, school, fire, or public safety official, and the Member is not in a position to refuse.
- (2) Any medically necessary and appropriate transportation ordered by an Affiliated Hospital is covered in full by the Plan.

Co-Payment: Except as provided in subsection (2) above, the Member will be responsible for \$75 or an amount not to exceed 50% of the Plan's reimbursement for the ambulance services, whichever is less.

5.14 Temporomandibular Joint Treatment

- (1) Temporomandibular Joint Syndrome (TMJ) is defined as muscle tension and spasms of musculature related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function, neurological, and personality dysfunctions.
- (2) When deemed medically necessary and provided or authorized by an Affiliated Physician, and approved by the Medical Director, the following services and treatment for Temporomandibular Joint Syndrome are Authorized Benefits and Services:
 - a. Office visits for medical evaluation and treatment.
 - b. Specialty referral for medical evaluation and treatment.
 - c. X-rays of the temporomandibular joint including contrast studies, but not dental X-rays.
 - d. Palliative therapy including TENS therapy and intraoral fixation.
 - e. Myofunctional therapy.
 - f. Surgery to the temporomandibular joint including but not limited to condylectomy, meniscectomy, arthrotomy and arthrocentesis.

- (3) Dental and orthodontic services, treatment, prosthesis, and appliances for or related to treatment for temporomandibular syndrome are not covered.

Coinsurance: The Member will be responsible for an amount not to exceed 50% of the Plan's reimbursement to the facility and to Affiliate Providers.

5.15 Emergency Inpatient Admission In Non-Affiliated Hospitals In the Service Area

- (1) If, in case of a Medical Emergency or Accidental Injury, a Member seeks emergency services at a non-affiliated Hospital and is admitted to the non-affiliated Hospital, the Plan will cover inpatient care at the admitting Hospital. Coverage will be limited to one (1) day of care, unless transferring the Member to an Affiliated Hospital or Referral Facility would jeopardize the Member's medical condition in the opinion of the Plan's Medical Director or designee. When a transfer would jeopardize a Member's medical condition, benefits will be extended until a transfer is practical or until discharge. In the event of a transfer, the cost of medically necessary and appropriate transportation is covered in full by the Plan. A transfer to an Affiliated Hospital or Referral Facility will be made under the supervision of the Plan. When a Member of his/her family refuses a transfer to an Affiliated or Referral Facility, continued care shall thereafter be the financial responsibility of the Member.
- (2) Outpatient follow-up services necessary for the continued treatment of a Medical Emergency or Accidental Injury are covered at the Member's designated Health Center only, unless specifically authorized in writing by the Plan's Medical Director or designee.

Subject to Deductible, then covered in full.

5.16 Out-of-Area Coverage

- (1) Out-of-area benefits shall be limited to inpatient and outpatient care for Medical Emergencies or Accidental Injuries only. Members traveling outside the Service Area are not covered for out-of-area obstetrical services and related Hospital care within four (4) weeks of the estimated date of delivery, as determined by the Affiliated Physician, whether or not the obstetrical services and related hospital care were required as a result of a Medical Emergency or Accidental Injury.
- (2) In order to be covered for services under this Section 5.16, the Member must notify the Plan within twenty-four (24) hours after admission to a Hospital or as soon as medically possible after admission where the Member is incapable of calling the Plan.
- (3) Outpatient follow-up services necessary for the continued treatment of a Medical Emergency or Accidental Injury are covered at the Member's Designated Health Center only, unless specifically authorized in writing by the Plan's Medical Director or designee.

Co-Payment: The Member will be responsible for \$100 per visit for covered emergency services. However, if the emergency results in the admission to a Hospital, this Co-Payment will not be assessed.

Inpatient Admission Subject to Deductible, then Covered in Full.

Outpatient follow up services, Out-of-Area, when authorized is subject to your office visit Co-Payment.

5.17 Hospice

(1) Eligibility

A Member is eligible for Hospice coverage when the individual is suffering from a disease or condition with a terminal prognosis. A Member shall be considered to have a disease or condition with a terminal prognosis if, in the opinion of an Affiliated Physician, the Member's death is anticipated within six (6) months after the date of admission to the Hospice. The fact that a Member lives beyond the six (6) month or less prognosis shall not disqualify the person from continued Hospice care. In order to be eligible for Hospice coverage, a Member must have knowledge of the illness and the life expectancy and elect to receive Hospice services rather than active treatment for the illness.

(2) Settings

The majority of Hospice care is provided in the Member's home. If the Member is eligible for Hospice services but does not have a family member or friend to provide the care necessary to allow the Member to remain in the home, an Affiliated Physician in conjunction with the Plan shall arrange for Hospice care in an Affiliated Facility.

(3) Hospice Services

Hospice care shall be under the direction of an Affiliated Physician and address the physical, psychological, social, and spiritual needs of the terminally ill Member and shall be designed to meet the related needs of the terminally ill Member's family through the periods of illness and bereavement.

Covered in full.

5.18 Language Services

The Plan provides an interpreter if the Member does not speak English and a sign language interpreter if the Member has a hearing impairment. For assistance, the Member must call the Plan's hotline at (313) 871-2000 or 1-800-826-2862 or the TDD/TTY line at 1-800-647-3777.

5.19 After Hours Care

After Hours Care is defined as medically necessary care for non-life threatening conditions such as colds, flu, sore throats, fever, diarrhea, upper respiratory symptoms, earache, minor burns, allergic reactions, sprains, strains, and similar conditions when such services are delivered when your doctor's office is closed and are inappropriate for a hospital emergency room.

Co-Payment:

Within Preferred Network: \$25

Within Total Health Care USA Network: \$25

ARTICLE VI. EXCLUSIONS AND LIMITATIONS

6.01 All benefits and services not specifically described as Authorized Benefits and Services in this Certificate are excluded from coverage under this Certificate.

6.02 Covered benefits that are not subject to Deductible include:

Primary Care Office Visits	Pediatric Immunizations
Well Child Visits	Mammograms
Specialist Office Visits	Pre-Post Natal Care
Annual Physical Exam	Outpatient Mental Health
Annual Well Woman Exam	Emergency Room Services

- 6.03 Medical, surgical, hospital, and similar services (except for an Emergency) obtained by a Member from providers other than Affiliated Providers, are not covered unless they are authorized in writing by the Plan's Medical Director or designee before their services are rendered.
- 6.04 Services which are not medically necessary are not covered. The final determination of medical necessity is made by the Plan's Medical Director or designee.
- 6.05 Services for disabilities associated with military service to which the Member is legally entitled and for which facilities are reasonably available to the Member are not covered.
- 6.06 Services for an occupational injury or disease for which services, payment, or reimbursement is available under any worker's compensation or employer's liability law are not covered.
- 6.07 Care for conditions that federal, state, or local laws require be treated in a public health facility is not covered.
- 6.08 Infertility treatment is not covered.
- 6.09 Services ordered by a court of competent jurisdiction are not covered, unless they are otherwise Authorized Benefits and Services.
- 6.10 Services provided during police custody are not covered, unless they are otherwise Authorized Benefits and Services.
- 6.11 Unless included in a Rider, outpatient prescription, or nonprescription drugs, prosthetic appliances, orthotic equipment, eyeglasses, vision exams, audiometric exams, hearing aids, durable medical equipment, skilled nursing care, and diet supplements are not covered.
- 6.12 Surgery and other services for cosmetic purposes, as determined by the Plan's Medical Director or his/her designee, are not covered.
- 6.13 Dental services and/or surgeries are not covered except in cases of multiple extractions or removal of unerupted teeth under general anesthesia where a concurrent medical condition exists.
- 6.14 Medical, surgical, and other health care procedures determined by the Plan's Medical Director to be experimental (including research studies) are not covered. Health services, which

are unusual, infrequently provided and not necessary for the protection of individual health, are not covered.

- 6.15 Reversal of voluntary, surgically-induced sterilization is not covered.
- 6.16 Services of private duty nurses are not covered unless they are authorized by the Plan's Medical Director or designee before the services are rendered.
- 6.17 Custodial care, domiciliary care or basic care in a residential, institutional, or other setting that is primarily for the purpose of meeting the Member's personal needs and which could be provided by persons without professional skills or training is not covered. Examples of custodial care include: assistance in bathing, dressing, eating, walking, getting in and out of bed, and taking medicine.
- 6.18 General housekeeping services and personal convenience items including, but not limited to, television and telephone services are not covered.
- 6.19 Health care benefits and services rendered as a result of a motor vehicle accident are not covered to the extent there is coverage under any insurance policy.
- 6.20 Services that constitute vocational rehabilitation or employment counseling, or that are in connection with examinations for insurance employment screening are not covered, except as they may be incidental to an annual health examination.
- 6.21 If a Member requests inpatient accommodations that are more expensive than those provided in this Certificate, the Member must pay the hospital the difference between those charges incurred and those allowable and payable by the Plan.
- 6.22 Hospital, medical, and surgical services for the primary purpose of sex transformation are not covered.

ARTICLE VII. SUBROGATION

- 7.01 Subrogation means that the Plan will have the same right as a Member to recover expenses for treatment of an injury or illness for which another person or organization is legally liable. To the extent the Plan provides services in such situations, the Plan will be subrogated to the Member's right of recovery against any responsible person or organization, including any other health plan or insurers on policies, including those issued to and in the name of the Member.
- 7.02 By acceptance of an identification card from the Plan, the Member agrees as a condition to receiving Authorized Benefits and Services under this Certificate, that the Member will make a good faith effort to pursue recovery from any liable person or organization and upon collection of any recoveries for any Authorized Benefits and Services provided by the Plan will reimburse the Plan. The Plan shall have a lien for any Authorized Benefits and Services rendered on any such recoveries whether by judgment, settlement, compromise, or reimbursement.

- 7.03 Members shall take such action, furnish such information and assistance, and execute such assignments and other instruments as the Plan may request to facilitate enforcement of the rights of the Plan hereunder.
- 7.04 A Member shall not compromise or settle a claim or take any action that would prejudice the rights and interests of the Plan without the Plan's prior written consent.
- 7.05 Refusal or failure of a Member, without good cause, to cooperate with the Plan under this Article, shall be grounds for termination of membership in the Plan and for recovery by the Plan from the Member for the value of services and benefits provided by the Plan.

ARTICLE VIII. COORDINATION OF BENEFITS

- 8.01 Benefits under this Certificate will be coordinated with all group health policies and/or other HMO benefits available to the Member under any policy or certificate that also has a coordination of benefits provision. The priority of responsibility under the coordinating insurance policies or certificates will be determined in the following manner as prescribed under Act No. 64 of the Public Acts of 1984:
- (1) The benefits of a policy or certificate that covers the person on whose expense the claim is based other than as a Dependent, shall be determined before the benefits of a policy or certificate which covers the person as a Dependent.
 - (2) Except as otherwise provided in subsection (3), if two (2) policies or certificates cover a person on whose expenses the claim is based as a Dependent, the benefits of the policy or certificate of the person whose birthday anniversary occurs earlier in the Calendar Year shall be determined before the benefits of the policy or certificate of the person whose birthday anniversary occurs later in the Calendar Year. If the birthday anniversaries are identical, the benefits of a policy or certificate that has covered the person on whose expenses the claim is based for the longer period of time shall be determined before the benefits of a policy or certificate that has covered the person for the shorter period of time. However, if either policy or certificate is lawfully issued in another state and does not have the coordination of benefits procedure regarding Dependents based on birthday anniversaries as provided in this subsection, and as a result each policy or certificate determines its benefits after the other, the coordination of benefits procedure set forth in the policy or certificate that does not have the coordination of benefits procedure based on birthday anniversaries shall determine the order of benefits.
 - (3) In the case of a person for whom claim is made as a Dependent minor child, benefits shall be determined according to the following:
 - a. Except as provided in paragraph c. below, if the parents of the minor child are legally separated or divorced, and the parent with custody of the child has not remarried, the benefits of the policy or certificate that covers the minor child as a Dependent of the custodial parent shall be determined before the benefits of a policy or certificate that covers the minor child as a Dependent of the non-custodial parent.

- b. Except as provided in paragraph c. below, if the parents of the minor child are divorced, and the parent with custody has remarried, the benefits of a policy or certificate that covers the minor child as a Dependent of the custodial parent shall be determined before the benefits of a policy or certificate that covers the minor child as a Dependent of the spouse of the custodial parent, and the benefits of a policy or certificate that covers the minor child as a Dependent of the spouse of the custodial parent shall be determined before the benefits of a policy or certificate that covers the minor child as a Dependent of the non-custodial parent.
- c. If the parents of the minor child are divorced, and the decree of divorce places financial responsibility for the medical, dental or other health care expenses of the minor child upon, either the custodial or the non-custodial parent, the benefits of the policy or certificate that covers the minor child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other policy or certificate that covers the minor child as a Dependent.

- 8.02 If Section 8.01 (1), (2) and (3) above do not establish an order of benefit determination, the benefits of a policy or certificate in connection with a group disability benefit plan that group disability plan has covered the person on whose expenses the claim is based for the longer period of time shall be determined before the benefits of a policy or certificate that has covered the person for the shorter period of time, subject to the following:
- (1) The benefits of a policy or certificate covering the person on whose expenses the claim is based as a laid-off or retired employee or a Dependent of a laid-off or retired employee shall be determined after the benefits of any other policy or certificate covering the person other than as a laid-off or retired employee or Dependent of a laid-off or retired employee.
 - (2) Subsection (1) shall not apply if either policy or certificate is lawfully issued in another state and does not have a provision regarding laid-off or retired employees and, as a result, each policy or certificate determines its benefits after the other.
- 8.03 Benefits under this Certificate shall not be reduced or otherwise limited because of the existence of another non-group contract that is issued as a hospital indemnity, surgical indemnity, specified disease, or other policy of disability policies as defined in Section 3400 of the Insurance Code of 1956, Act 218 of the Public Acts of 1956, being Section 500.3400 of the Michigan Compiled Laws.
- 8.04 Health care benefits and services rendered as a result of a motor vehicle accident are not covered to the extent there is coverage under any other policy.
- 8.05 The Plan is not required to pay claims or coordinate benefits for services that are not provided or authorized by the Plan and that are not Authorized Benefits and Services under this Certificate.

ARTICLE IX. CHANGES IN RATES, CERTIFICATE, OR STATUS OF MEMBERS

- 9.01 The Plan will not make adjustments in the rate(s) used to determine Premiums, nor in the terms and/or conditions of this Certificate with less than thirty (30) days written notice to the Remitting Agent.
- 9.02 The Subscriber must notify the Plan in writing within thirty (30) days of any changes in the status of each Member as a result of divorce, death, birth, legal adoption, changes in legal residence of children, changes in address, change of telephone number, entrance into or return from military service, or when a dependent has been employed by a company offering health benefits.

ARTICLE X. TERMINATION OF GROUP COVERAGE

- 10.01 The Certificate and the Group Operating Agreement shall continue in effect for one (1) year from the effective date and from year to year thereafter. The Plan may terminate this Certificate and the Group Operating Agreement without notice if the Group fails to pay the Premium within the Grace Period. In the event the Premium is not paid within the Grace Period, this Certificate terminates and all Authorized Benefits and Services cease retroactively as of 11.59 p.m. on the due date, unless otherwise expressly agreed upon by the Plan in writing. In the event of termination, the Plan reserves the right to recover from the Group the costs of services rendered to the Members during the period following the due date and to reject claims submitted by providers for services rendered during the period following the due date.

ARTICLE XI. TERMINATION OF A MEMBER'S COVERAGE

- 11.01 If this Certificate is terminated pursuant to Article X, the Member's coverage shall terminate at the time specified in Article X without further action of the Plan.
- 11.02 If a Member ceases to meet the eligibility requirements of the Group Operating Agreement and this Certificate, coverage shall terminate (subject to the conversion rights under Article XII) as follows:
- (1) If the Subscriber ceases to be a member of the Group, Authorized Benefits and Services for the Subscriber and enrolled Dependents will be continued only until the end of the month for which Premiums have been paid without any further action by the Plan.
 - (2) Upon the death of the Subscriber, all Authorized Benefits and Services will be continued for enrolled Dependents only until the end of the month for which Premiums have been paid without any further action by the Plan.
 - (3) In the event of divorce or legal separation of Subscriber and Spouse, all Authorized Benefits and Services will be continued for the Spouse only until the end of the month for which Premiums have been paid without any further action by the Plan.
 - (4) In the event a Member becomes a member of the Armed Services of the United States, all Authorized Benefits and Services shall terminate as to such Member as of that date without any further action by the Plan.

- (5) Coverage shall terminate at the end of the month in which a Dependent child attains the age of twenty-six (26).
 - (6) In the event a Member transfers residence outside the Service Area, Authorized Benefits, and Services may be terminated.
 - (7) Coverage shall terminate for the Dependent child if the Dependent child becomes eligible for coverage through their employer.
- 11.03 The Plan may rescind a Member's coverage under this Certificate for intentional misrepresentation of a material fact on the Enrollment Application.
- 11.04 The Plan may terminate a Member's coverage for providing false or misleading information or withholding material information on any required plan form or in applying for or seeking any health care under the terms of this Certificate. Termination of coverage is effective ten (10) days after notice of termination is given by the Plan.
- 11.05 The Plan may terminate a Member's coverage if that Member fails to report theft or loss of a Member identification card within the time required by Section 4.06. Termination of coverage is effective immediately.
- 11.06 The Plan may terminate a Member's coverage if that Member knowingly fails or refuses to furnish information requested by the Plan. Termination of coverage is effective ten (10) days after notice of termination is given by the Plan.
- 11.07 The Plan may terminate a Member's coverage if the Member aids, attempts to aid, or knowingly permits any other person not a Member to obtain benefits or services from or through the Plan. Termination of coverage is effective immediately.
- 11.08 The Plan may terminate a Member's coverage if the Member refuses or fails, without good cause, to cooperate with the Plan pursuant to Article VII.
- 11.09 The Plan may terminate the enrollment of a Member for the inability of the Member to establish a satisfactory relationship between the Member and an Affiliated Physician, including failure to comply with a prescribed treatment regimen, after reasonable attempts at establishing a satisfactory relationship with not less than two (2) Affiliated Physicians have proven unsuccessful, subject to the Member's rights under the Plan's grievance procedure to determine whether such a situation exists. Termination is effective thirty (30) days after notice of termination is given by the Plan.
- 11.10 Members may elect to terminate their coverage during Group Open Enrollment that occurs once a year, or in the event that the member ceases to meet the eligibility requirements as defined in this document or the Group Operating Agreement, by giving written notice to the Plan and the Remitting Agent.
- 11.11 Benefits for any authorized inpatient admission to a Hospital or skilled nursing facility that began prior to the effective date of termination will be provided only until the date of termination or until the last day of coverage.

ARTICLE XII. CONTINUATION COVERAGE AND CONVERSION

12.01 CONTINUATION OF GROUP COVERAGE OPTION

- (1) A Member may be entitled under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue his/her coverage under this Certificate by making periodic payments directly to his/her Group. Subject to its terms and conditions, and timely payment, this Certificate shall be continued for such members for a maximum of eighteen (18) months from the date of termination of employment or thirty-six (36) months from the date of death, divorce or loss of Dependent status, or until the continuation of Coverage is no longer available through the Group.
- (2) Upon election to continue coverage for eighteen (18) months or thirty-six (36) months, payment shall be made by the member to the Remitting Agent who shall pay the Plan in advance at the rate and in accordance with the frequency schedule established by the Plan, unless otherwise agreed to by the Plan in writing. If the Premium is not received within thirty-one (31) days of the due date, this Certificate may terminate without notice. If this Certificate is terminated, the Plan reserves the right to recover from the Group the cost of services rendered during the period following the due date.
- (3) A Member who elects to receive continuing coverage for a maximum of eighteen (18) months or thirty-six (36) months, as applicable, may convert to an individual contract at the end of the eighteen (18) month or thirty-six (36) month period.

12.02 CONVERSION OPTION

- (1) A member who loses eligibility for coverage under this Certificate as a Group member, for other than his/her violation of this Certificate, is entitled to convert this Certificate to an individual contract by making Application within thirty (30) days of receiving notification of the event which made the Member ineligible for Group coverage. Evidence of good health will not be required by the Plan in order exercise this conversion option.
- (2) Individual coverage will be of the type currently being offered by Total Health Care USA, and may not be identical to the health care benefits provided by this Group Certificate.
- (3) If a Member fails to make timely payment to the Plan, the Member's coverage under the Individual contract will be subject to termination in accordance with the terms of the contract.

Notes

Notes



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